

Burson Counseling- New Client Information- Families & Couples
Jackie Burson, MS, NCC, LPC, RPT
Brooke Komar, MS, LPC, LMHC, ATR

Client Name: **(his)** _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email _____

Age: _____ Date of Birth: _____

Client Name: **(her)** _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email _____

Age: _____ Date of Birth: _____

Employer **(his)**: _____

Employer **(her)**: _____

Why are you and your spouse or family seeking counseling:

How would you rate the intensity of the problem or concern that brought you in:

1 2 3 4 5

Not Intense

Moderately Intense

Extremely Intense

How long have you had the current problem:

In what ways have you attempted to cope with this problem:

Have you been in counseling before?

If so, please provide a brief description of treatment:

Former Counselor:_____ Phone:_____ Dates:_____

ABOUT HER

Where did you attend public school?_____

Where did you attend college?_____

Relationships

Relative	Name	Living (Yes/NO)	Age or age at death	Deceased? Yes No	Occupation

Describe any other significant relationships other than relatives: _____

Please check any past or present problems/concerns in your family:

- | | | |
|--|---|--|
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Serious Illness | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Relocations | <input type="checkbox"/> Psychiatric Disorders | <input type="checkbox"/> Physical/Sexual Abuse |
| <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Attempted Suicide |
| <input type="checkbox"/> Financial Crisis | <input type="checkbox"/> Parenting/Step Parenting | <input type="checkbox"/> Health |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Codependence | <input type="checkbox"/> Debt |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Failure/Fears | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Grieving | <input type="checkbox"/> Sexual Conflicts | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Panic/Anxiety Attacks | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Anger/Agression | <input type="checkbox"/> Career Concerns | <input type="checkbox"/> Laziness |

Other _____

Did you experience any of the following problems, if yes please explain:
Family abuse, legal problems, learning problems in school, difficulty growing up?

Please explain:

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with _____

Who is your doctor: _____ Number: _____

When was your last visit: _____

List all medications/drugs you are currently taking or have taken within the last year: _____

Are there any health concerns from your doctor?

ABOUT HIM

Where did you attend public school? _____

Where did you attend college? _____

Relationships

Relative	Name	Living (Yes/NO)	Age or age at death	Deceased? Yes No	Occupation

Describe any other significant relationships other than relatives: _____

Please check any past or present problems/concerns:

- | | | |
|--|---|--|
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Serious Illness | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Relocations | <input type="checkbox"/> Psychiatric Disorders | <input type="checkbox"/> Physical/Sexual Abuse |
| <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Attempted Suicide |
| <input type="checkbox"/> Financial Crisis | <input type="checkbox"/> Parenting/Step Parenting | <input type="checkbox"/> Health |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Codependence | <input type="checkbox"/> Debt |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Failure/Fears | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Grieving | <input type="checkbox"/> Sexual Conflicts | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Panic/Anxiety Attacks | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Anger/Agression | <input type="checkbox"/> Career Concerns | <input type="checkbox"/> Laziness |

Other _____

Did you experience any of the following problems, if yes please explain:
Family abuse, legal problems, learning problems in school, difficulty growing up?

Please explain:

Who in your family do you currently feel closest to? _____
Most distant from? _____ In most conflict with _____

Who is your doctor: _____ Number: _____

When was your last visit: _____

List all medications/drugs you are currently taking or have taken within
the last year: _____

Are there any health concerns from your doctor?

About Your Family

Child's Name & age: _____

Child's Name & age: _____

Child's Name & age: _____

Child's Name & age: _____

Describe any past/current problems with children:

**PROFESSIONAL DISCLOSURE STATEMENT- BursonCounseling
Jackie Burson, MS, NCC, LPC, RPT & Brooke Komar, MS, LPC, LMHC, ATR**

Therapy Policies and Services

Welcome! We are committed to providing you with quality care. This information packet is intended to acquaint you with what you can expect, and address some of the typical areas of concern, especially for the first-time client.

Qualifications: Jackie Burson is a graduate from Texas Woman's University in Counseling and Development. Brooke Komar is a graduate from Emporia State University in Art Therapy. We are qualified to counsel according to the Texas Department of Health. Our formal education has prepared us to do individual counseling with children, adolescents/teens, adults and families.

Experience: Throughout our master's program and under supervision since completing our formal education, we have counseled many individuals, family and group sessions in the school and agency setting, clinical internships, and in private practice.

INFORMED CONSENT

Counseling Relationship: While we work together, our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. Please do not invite us to social gatherings, offer us gifts, ask us to write references for you, or ask us to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. Our in-person contact will be limited to counseling sessions you arrange with us. You may leave messages for me at 214-926-2184 and I will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the

right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.

We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints to the Texas Department of Health, 512-834-6658.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, we may require you to sign a release so we may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with us you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with us and sign a release that enables us to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, we may consider this your decision to change counselors and reserve the right to terminate your counseling.

We also reserve the right to postpone and /or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, we reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Referrals: We recognize that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or we may believe that a referral is needed. In that case, we will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and /or alternatives. Certain aspects of treatment may require evaluation through psychological testing or medication. In such cases, a referral to a psychiatrist or medical doctor may be made. Ongoing dialogue with these professionals would be maintained to manage the counseling process effectively.

Fees: In return for a fee of \$ 120 per 50 minute session, we agree to provide counseling services for you. By consenting to treatment, you acknowledge (to you or your minor child) and agree to pay them at each session. Cash, credit cards or personal checks made out to "*Jackie Burson*" are acceptable for payment and due by the end of each session. Some insurance companies may cover part of this cost. You will be given a receipt at the end of your session for use in filing insurance claims.

If you become involved in litigation that requires our participation (even if the subpoena is sent from the opposite side of the case), and due the complexity and

difficulties of legal involvement, **we charge \$250 per hour for preparation for and/or attendance at any legal proceedings. (A \$500 fee is due upfront before going to court).** There is a \$25 returned check fee.

Cancellation: If you need to cancel an appointment, 24 hours notice is required. If you miss an appointment without sufficient notification you WILL BE CHARGED \$100. Missed appointments CANNOT be filed with insurance.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) We determine that you are a danger to yourself or someone else; b) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; c) you disclose sexual contact with another mental health professional; d) We are ordered by a court to disclose information; e) you direct me to release your records; or f) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first.

Client's Signature (parent if under 18)	Date
---	------

Counselor's Signature	Date
-----------------------	------

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective August 1, 2004

Use and disclosure of protected health information for the purposes of providing professional counseling services is sometimes required. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment

Use and disclose health information to:

- _ Provide, manage or coordinate care to consultants, referral sources, or physicians.
- _ As patients gives permission via "Informed Consent" form.

Healthcare Operations

- _ Use and disclose health information for:
 - _ Review of treatment procedures.
 - _ Review of business activities.
 - _ Staff training and care within our practice.
 - _ Compliance and licensing activities.

Other Uses and Disclosures Without Your Consent

- _ Mandated reporting.
- _ Emergencies.
- _ Criminal damage.
- _ Appointment scheduling.
- _ Treatment alternatives.
- _ As required by law.

By signing below, you attest that you have read and have been made aware of my rights of confidentiality as a mental health consumer. Full HIPPA Compliance Rules and Regulations are posted in the therapist's office at all time, and may be read and copied for consumer upon request.

Client/Guardian Printed Name

Relationship to Client

Client/Guardian Signature

Date Signed